HEALTH PROFESSIONS
EDUCATION FOUNDATION
Giving Golden Opportunities

Allied Healthcare

Scholarship Program Application

Made possible through funding from Kaiser Permanente

Giving Golden Opportunities by:

Increasing the supply of health professionals practicing in underserved areas

Improving access to healthcare in rural and urban areas of California

Helping students to pursue a career in the health professions

Awarding health professionals who are dedicated to practicing in underserved communities

Application Instructions

The **Allied Healthcare Scholarship Program** is offered to students enrolled or accepted in an allied healthcare education program. Students who attend a community college program are eligible for a scholarship up to **$2,000**. Students who attend a university program are eligible for a scholarship up to **$2,500**.

Applications for the Allied Healthcare Scholarship are accepted biannually in March and September. Scholarships funded under this program are intended to pay or repay tuition, required fees, books, supplies, and educational equipment costs related to the student's allied healthcare education. All awards are subject to the availability of funding.

The purposes of the Allied Healthcare Scholarship are: 1) to encourage allied healthcare professionals to practice direct patient care in a medically underserved area of California; 2) to increase the number of appropriately trained allied healthcare professionals; and 3) to encourage underrepresented groups to pursue the allied healthcare profession.

Although this scholarship is funded by Kaiser Permanente, awardees of this program are not obligated to work for Kaiser Permanente.

SELECTION CRITERIA

Selection for the Allied Healthcare Scholarship is based solely on information contained in the application and supporting documentation. Selection for awards is based on the following criteria:

Work Experience - allied healthcare and non-allied healthcare work experience in a medically underserved area (MUA).

Financial Need - actual or potential financial difficulty in completing education in the absence of the scholarship.

Career Goals - professional goals for the next five to ten years.

Community Service - documented volunteer service and/or activities, particularly in a MUA.

Community Background - family structure and community where you grew up; for example, rural, inner city/urban, suburban, or MUA.

Academic Performance - prior and current academic performance; potential for future academic success.

Priority will be given to: Students who will complete their allied healthcare program within the next two years. Awards are made on a competitive basis.

SCHOLARSHIP ELIGIBILITY

To be eligible for a scholarship, students must sign a contract with the Office of Statewide Health Planning and Development and agree to the following terms:

Graduation Requirements: Your graduation date may impact the amount of funding you are eligible to receive.

Be enrolled or accepted in one of the following allied healthcare programs: Diagnostic Medical Sonography, Medical Imaging, Medical Laboratory Technology, Occupational Therapy, Pharmacy, Pharmacy Technician, Physical Therapy, Respiratory Care, Social Work, Surgical Technician, Radiologic Technology, Radiation Therapy Technology, Nuclear Medicine Technology, and Clinical Laboratory Science.

Nursing students are not eligible to apply for this program. Please visit the Foundation's web site at www.healthprofessions.ca.gov and download the Associate or Baccalaureate Degree Nursing Scholarship Application for eligibility information.

Be a full-time or part-time student (no less than 6 units) in a California accredited school.

Immediately following graduation, complete a 1-year service obligation to work in a medically underserved area of California providing direct patient care in your field of study.

Or

Immediately following graduation, complete 100 volunteer work hours for every $2,000 scholarship or 150 volunteer work hours for every $2,500 scholarship.

Maintain a minimum cumulative GPA of 2.0 each year funds are received.

Be a U.S. citizen or **permanent resident** and a California resident.

Application Instructions (continued)

SCHOLARSHIP APPLICATION

Submit the following:

1. Official Transcript(s) related to your allied healthcare education
If you are a student in your first year of the program and your transcripts do not reflect your allied healthcare education, submit your most current transcript.

The transcript must be marked official by the school and delivered to the Foundation in a sealed envelope. The Foundation will not accept unofficial transcripts, copies or print outs of transcripts, or transcripts in a broken envelope.

2. Personal Statements (Part D of the Application)
Attach your personal statements to the application. Your statements must be typed. Please limit all Personal Statements to not more than 6 pages. Restate and number each question along with your answer.

3. Two letters of recommendation
Letters of recommendation must be current or dated within the last six months of the application deadline. The letters must be on letterhead or include the author's title, name of employer, mailing address, and phone number. It is recommended that at least one letter be from a faculty member. Letters of recommendation that confirm community service are encouraged.

4. Graduation Date Verification Form
The program director or a faculty member authorized to sign on the director's behalf must sign this form. The Graduation Date Verification Form is enclosed as part of the scholarship application. Students can also download this form from the Foundation's Web site at www.healthprofessions.ca.gov.

5. Resume (optional)
If available, please attach a copy of your resume.

6. Student Aid Report (SAR)
Students must submit the final 2005-2006 SAR. The SAR must indicate the student's expected family contribution (EFC). The FAFSA is available from all college financial aid offices and is also available on the Internet at www.ed.gov/offices/OPE/express.html.

Or

2004 Federal Tax Return with all W-2s
Students who do not apply for financial aid must submit complete copies of their 2004 Federal tax return with all W-2s. Do not submit State tax returns. State tax returns will not be accepted in lieu of the Federal tax return.

APPLICATION SUBMISSION

Applications must be postmarked by the deadline. Only complete applications will be reviewed. Each part of the application must be completed. All supporting documentation must be submitted. The Foundation will not notify students if their application is received incomplete. Students are urged to contact the Foundation at (800) 773-1669 prior to the final filing date to verify if their application was received complete. Do not bind or submit applications in a loose-leaf binder.

NOTIFICATION OF AWARDS

The Foundation will notify students of their application results within eight weeks of the final filing date.

Spring Application Postmark Deadline: March 24, 2005
Fall Application Postmark Deadline: September 8, 2005

Submit applications to:

Health Professions Education Foundation
Allied Healthcare Scholarship Program
818 K Street, Suite 210
Sacramento, CA 95814
(800) 773-1669 or (916) 324-6500

Allied Healthcare Scholarship Program Application

Do you owe an existing service obligation to another entity? ☐ Yes ☐ No

If yes, please explain. _____

_____

Please refer to the application instructions when completing the application. Complete each part of the application form. Make sure all supporting documents are submitted with your application. Applications and all supporting documents must be postmarked by the due date. Late applications will not be evaluated.

PART A – PERSONAL INFORMATION

(Please type or print your answers in the space provided) Applicants may apply for only one award using this application.

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

County: _____

Permanent Address: _____

City: _____ State: _____ Zip: _____

County: _____

Home Phone: ____ _____ Work Phone: _____

Social Security # _____- ___ - _____ CA Drivers License # _____

Date of birth: ____ ____ ____ Age: _____ Gender: Male Female

Marital Status: ____ Unmarried ____ Married

Number of dependents other than self and spouse: _____

Are you a previous awardee of the Foundation? ☐ Yes ☐ No

If yes, please enter the contract # _____

Are you currently employed as a licensed health professional? ☐ Yes ☐ No

If yes, provide license # _____ Expiration date_____ _____ ____

Are you the first in your family to attend college? ☐ Yes ☐ No

Which best describes your ethnic background:

☐ Asian American ☐ Pacific Islander ☐ African American

☐ Caucasian ☐ Native American ☐ Hispanic/Latino

☐ Other (Please specify) _____

If Native American, please specify tribal affiliation and submit verification:

_____

List any languages you can speak, read, and write in addition to English. Check all that apply.

1 _____ ☐ Speak ☐ Read ☐ Write

2 _____ ☐ Speak ☐ Read ☐ Write

Are you a citizen or permanent resident of the U.S.? ☐ Yes ☐ No

Are you a California resident? ☐ Yes ☐ No

PART B – WORK EXPERIENCE

Please list all paid and/or unpaid work experience you have had. List most recent employer first. Attach additional work history on page 5 (maximum of 5 employers).

Employer's Name: _____

Address: _____

City:_____ State: _____ Zip: _____

County: _____

Your Supervisor's Name: _____ Office Phone: _____

Your Position/title: _____ Monthly Salary: _____

☐ Paid worker **OR** ☐ Non-paid ☐ Full-time **OR** ☐ Part-time

Employment Start Date ____ ___ ___ Employment End Date: ____ ___ ___

Average hours worked (please choose only one):

____/day ____/week ____/ month

Brief description of your job duties: _____

_____

_____

_____

_____

FOR OFFICIAL USE ONLY

Recd:	**Compl / Inc:**	**Omitted:** App Pgs GDV EVF SAR TAX LoR Oth
App Inquiry: (- -) (- -)		**HPEF Contact:** **for:**
Input By:	**MUA: Yes / No**	**CT#:**
Reviewed By:		**Comments:**

Allied Healthcare Scholarship Program Application

PART C – COMMUNITY BACKGROUND

For each age category below, list the city, county, and state you grew up in. Check all items that best describe your socioeconomic background.

Age Category	Rural	Inner City/Urban	Suburban	Poor	Middle-class
Birth-10 years	☐	☐	☐	☐	☐

City:_____ County:_____ State:_____

Age Category	Rural	Inner City/Urban	Suburban	Poor	Middle-class
11-20 years	☐	☐	☐	☐	☐

City:_____ County:_____ State:_____

Age Category	Rural	Inner City/Urban	Suburban	Poor	Middle-class
21-30 years	☐	☐	☐	☐	☐

City:_____ County:_____ State:_____

Age Category	Rural	Inner City/Urban	Suburban	Poor	Middle-class
31-40 years	☐	☐	☐	☐	☐

City:_____ County:_____ State:_____

Age Category	Rural	Inner City/Urban	Suburban	Poor	Middle-class
41 + years	☐	☐	☐	☐	☐

City:_____ County:_____ State:_____

PART D – PERSONAL STATEMENTS

Attach your personal statements to the application. Your statements must be typed. Restate and number each question along with your answer.

1. What kind of work do you think you'll be doing in five years?
2. What is your vision of your professional future in ten years?
3. Describe any community service, volunteer activities, or club memberships within the past two years. **Please attach any letters of recommendation you may have. Do not include experience for which you received academic credit.**
4. Briefly describe your family background including: your father's and mother's occupation, annual income, marital status, and number of dependents including yourself.
5. Describe how your background is relevant to your interest in pursuing an allied health profession career. Do you see your background as an advantage, disadvantage or both?
6. What kind of work would you like to do immediately after graduation?

PART E – QUESTIONNAIRE

Where did you hear about the Allied Healthcare Scholarship Program? (Check all that apply)

☐ School ☐ Work (employer or co-worker) ☐ Friend/Acquaintance
☐ Foundation Web site ☐ Other Web site ☐ Advertisement ☐ TV ☐ Radio
☐ Newspaper or publication (please specify)_____
☐ Organization or Affiliation (please specify)_____
☐ Other source (please specify)_____

Where did you receive the Allied Healthcare Scholarship Program form? (Check all that apply)

☐ Financial Aid Office ☐ Program Director/Instructor ☐ Foundation office
☐ Foundation Web site ☐ Other Web site ☐ Work (employer/co-worker)
☐ Friend/Acquaintance
☐ Other please specify_____

PART F – APPLICATION CERTIFICATION

I certify that all information in this application is true and accurate to the best of my knowledge. I authorize the Health Professions Education Foundation to verify any information submitted as part of this application. I understand that falsification of information contained in this application will disqualify my application and the respective licensing Board will be notified.

I understand that if falsification is discovered after I have been awarded, I will be required to repay all funds awarded, plus interest and administrative fees.

I understand that once submitted my application and supporting documents become the rights of the Health Professions Education Foundation. I also understand that my personal statements become the property of the Foundation and may be used, including but not limited to, advertising/marketing, program reports, newsletters, and other publications.

Printed Name: (last name, first name, middle initial)

_____

Applicant's Signature: _____ Date: _____

SUBMIT APPLICATIONS TO:

Health Professions Education Foundation
Allied Healthcare Scholarship Program
818 K Street, Suite 210
Sacramento, CA 95814

SPRING POSTMARK DEADLINE: MARCH 24, 2005
FALL POSTMARK DEADLINE: SEPTEMBER 8, 2005

APPLICATION CHECKLIST

☐ **1. Official Transcript(s) related to your allied health education**
☐ **2. Personal Statements**
☐ **3. Two (2) Letters of Recommendation**
☐ **4. Graduation Date Verification Form**
☐ **5. Resume** (optional)
☐ **6. 2005-2006 Student Aid Report (SAR)**
or
2004 Federal Tax Return and all W-2s

Additional Work History

Please list all paid and/or unpaid work experience you have had. List most recent employer first (maximum of 4 employers).

Employer's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

County: _____

Your Supervisor's Name: _____ Office Phone: _____

Your Position/title: _____ Monthly Salary: _____

❑ Paid worker **OR** ❑ Non paid ❑ Full-time **OR** ❑ Part-time

Employment Start Date: ___ ___ ___ Employment End Date: ___ ___ ___

Average hours worked (please choose only one): ___/day ___/week ___/ month

Brief description of your job duties: _____

_____

_____

_____

_____

Employer's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

County: _____

Your Supervisor's Name: _____ Office Phone: _____

Your Position/title: _____ Monthly Salary: _____

❑ Paid worker **OR** ❑ Non paid ❑ Full-time **OR** ❑ Part-time

Employment Start Date: ___ ___ ___ Employment End Date: ___ ___ ___

Average hours worked (please choose only one): ___/day ___/week ___/ month

Brief description of your job duties: _____

_____

_____

_____

_____

Employer's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

County: _____

Your Supervisor's Name: _____ Office Phone: _____

Your Position/title: _____ Monthly Salary: _____

❑ Paid worker **OR** ❑ Non paid ❑ Full-time **OR** ❑ Part-time

Employment Start Date: Employment End Date:

Average hours worked (please choose only one): ___/day ___/week ___/ month

Brief description of your job duties: _____

_____

_____

_____

_____

Employer's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

County: _____

Your Supervisor's Name: _____ Office Phone: _____

Your Position/title: _____ Monthly Salary: _____

❑ Paid worker **OR** ❑ Non paid ❑ Full-time **OR** ❑ Part-time

Employment Start Date: Employment End Date:

Average hours worked (please choose only one): ___/day ___/week ___/ month

Brief description of your job duties: _____

_____

_____

_____

_____

GRADUATION DATE VERIFICATION FORM

***Must be completed by the Program Director or the director's designee.**

The student named below is applying for a scholarship from the Health Professions Education Foundation. This form is required for the application to be considered. Please return this form to the Foundation with original signature.

Applicant's Name: _____

Allied Healthcare Specialty: _____

School: _____

Address: _____

City: _____ County: _____ State: _____ Zip: _____

Year Entered: _____ Expected Graduation Date: _____
Month/Year Month/Year

Enrollment Status: Full-time ☐ Part-time ☐ # of units currently enrolled: _____

Please comment on the student's performance and potential for academic success.

_____

_____

_____

_____

_____

_____

_____

_____

This form was completed by

Name: (Please Print) _____ Title: _____

Signature: _____ Date: _____

Phone Number: ( )_____

Please check one:

☐ I certify that I am the Program Director.

☐ I certify that I am authorized to sign this document on behalf of the Program Director.

Allied Healthcare Scholarship Program

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